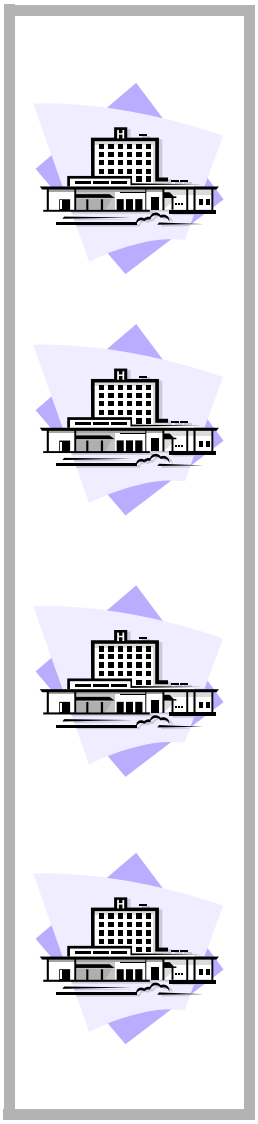

Medicaid Indian Health Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

This publication supersedes all previous Medicaid Indian Health Services handbooks. Published by the Montana Department of Public Health & Human Services, April 2006.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Relations

For questions about enrollment, eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Medicaid Client Help Line

Clients who have Medicaid or PASSPORT questions may call the Montana Medicaid Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

PASSPORT Program Officer

For questions concerning the PASSPORT Program:

PASSPORT Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

IHS Program Officer

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

IHS Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Montana Tribal Nations

Assiniboine and Souix Tribes

Fort Peck Council
P.O. Box 1027
Fort Peck Agency
Poplar, MT 59255
(406) 768-5155 Phone
(406) 768-5478 Fax

Blackfeet Tribe

Blackfeet Tribal Business Council
Box 850
Blackfeet Agency
Browning, MT 59417
(406) 338-7179 Phone
(406) 338-7530 Fax

Little Shell Tribe

Little Shell Tribe
Box 1384
105 Smelter Ave. Mini Mall
Great Falls, MT 59403
(406) 452-2892 Phone
(406) 452-2982 Fax

Chippewa Cree Tribe
Chippewa Cree Business Committee
Rocky Boy Route #544
Rocky Boy's Agency
Box Elder, MT 59521
(406) 395-4282 Phone
(406) 395-4497 Fax

Salish and Kootenai Tribe
Confederated Salish and Kootenai
P.O. Box 278
Flathead Agency
Pablo, MT 59855
(406) 675-2700 Phone
(406) 675-2806 Fax

Northern Cheyenne Tribe
Northern Cheyenne Tribal Council
P.O. Box 128
Northern Cheyenne Agency
Lame Deer, MT 59043
(406) 477-6284 Phone
(406) 477-6120 Fax

Crow Tribal Council
Box 159
Crow Agency, MT 59022
(406) 638-2601 Phone
(406) 638-3881 Fax

Fort Belknap Tribal Council
RR #1, Box 66
Harlem, MT 59526-9998
(406) 353-2205 Phone
(406) 353-2797 Fax

Indian Health Services Centers

Browning Indian PHS Indian Hospital
Hospital Circle
Browning, MT 59417
(406) 338-6154

Crow Agency PHS Indian Hospital
Hospital Road
Crow Agency, MT 59022
(406) 638-3461

Pryor PHS Indian Health Station
Main Street
Pryor, MT 59066
(406) 259-9813

Lodge Grass PHS Indian Health Center
Main Street
Lodge Grass, MT 59050
(406) 639-2317

Poplar PHS Indian Health Center
107 H Street
Poplar, MT 59255
(406) 768-3491

Lame Deer PHS Indian Health Services
100 Cheyenne Avenue
Lame Deer, MT 59043
(406) 477-6700

Hays PHS Indian Health Center
123 White Crow Canyon Road
Hays, MT 59527
(406) 673-3777

Heart Butte PHS Indian Health
20 Disney
Heart Butte, MT 59448
(406) 338-2151

Fort Belknap PHS Indian Health Center
456 Gros Ventre Avenue
Harlem, MT 59526
(406) 353-3100

Rocky Boy Health Center
RR 1, Box 664
Box Elder, MT 59521
(406) 395-4486 (638 compacted Tribe)

Confederated Salish and Kootenai Tribal Health/Human Services
P.O. Box 880, Mission Drive
St. Ignatius, MT 59865
(406) 745-3525

Key Web Sites

Web Address	Information Available
Provider Information Web Portal www.mtmedicaid.org or www.dphhs.mt.gov/medicaid/	• Medicaid information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more • Log in to Montana Access to Health
CHIP Website www.chip.mt.gov	Information on the Children's Health Insurance Plan (CHIP)
Centers for Disease Control and Prevention (CDC) website www.cdc.gov/nip	Immunization and other health information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider services • EDI support • Enrollment • Manuals • Software • Companion guides • FAQs • Related links

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for Indian Health Services (IHS) providers who provide services to clients who are eligible for both Medicaid and Indian Health Services.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information Web Portal (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to the Indian Health Services program:

- Code of Federal Regulations (CFR)
  - 42 CFR Part 136
- Montana Codes Annotated (MCA)
  - 53-6-101
- Administrative Rules of Montana (ARM)
  - ARM 37.82.101

Providers are responsible for knowing and following current laws and regulations.

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information Web Portal (see *Key Contacts*).

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to Indian Health Service (IHS) providers who provide services to clients who are eligible for both Medicaid and IHS. Like all health care services received by Medicaid clients, these services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

Members of federally recognized Indian Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency of the U.S. Public Health Service, Department of Health and Human Services. The IHS operates a comprehensive health service delivery system for approximately 1.5 million of the nation's two million American Indians and Alaska Natives. There are more than 550 federally recognized tribes in the United States. The members live mainly on reservations and in rural communities in 34 states, mostly in the Western U.S. and Alaska.

The Montana Medicaid Program covers most medical services for Medicaid-eligible Native Americans who receive those services though an Indian Health Service (IHS) facility or other approved tribal provider. By law, the Medicaid Program acts as the "pass-through" agency for these services, which are funded with 100 percent federal funds.

Provider requirements

IHS physicians must meet Montana Medicaid's State Plan requirements. Physician requirements are available in the *Physician Related Services* manual available on the mtmedicaid.org website. Montana Medicaid does not require IHS physicians to hold a Montana physician license; however, they must meet the substantive licensure requirements. The Department must be satisfied that the physicians can demonstrate they are authorized to practice medicine. A copy of the physician's current license from another state would satisfy this requirement.

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive

any medically necessary covered service, including all outpatient hospital services described in this manual. All applicable PASSPORT To Health and prior authorization requirements apply.

Coverage of Specific Services

Medicaid covers the same services for clients who are enrolled in Medicaid and IHS as those clients who are enrolled in Medicaid only. All requirements for Medicaid services (such as prior authorization, PASSPORT and others) also apply to Medicaid enrolled clients who qualify for IHS services. Requirements for specific services are covered in the Medicaid provider manual for the service provided (e.g., *Physician Related Services*; *Durable Medical Equipment, Prosthetics, Orthotics and Supplies*, etc.). All manuals are available on the mtmedicaid.org website or by contacting Provider Relations (see *Key Contacts*). The following services have special conditions.

Abortions and sterilizations

Medicaid covers abortions and sterilizations **only** when all requirements are met. Refer to the *Physician Related Services* manual or the *Hospital Outpatient* manual for requirements and essential forms.

Lab and x-ray services

Lab and x-ray services are included in the visit and may not be billed separately to Medicaid.

Outpatient services

Outpatient services include all professional services as well as medical supplies, pharmaceuticals, imaging and diagnostic services, and laboratory services.

Prescription drugs

The initial prescription is included in the visit and may not be billed separately to Medicaid. Refills may be billed to Medicaid. The Medicaid prescription drug program covers:

- Legend drugs
- Medicaid covers the following **prescribed** over-the-counter products manufactured by companies who have signed a federal rebate agreement:
  - Aspirin*****
  - Insulin
  - Laxatives*****
  - Antacids*****

*****Nursing facilities are responsible for providing over-the-counter laxatives, antacids and aspirin to their residents.

  - Head lice treatment
  - H2 antagonist GI products
  - Bronchosaline
- Vaccines except:
  - For children 18 years old and under, coverage is limited to vaccines **not** available directly to physicians and clinics through the Vaccines for Children (VFC) program.
  - For clients with Medicare Part B insurance, Medicaid excludes pneumonia and flu vaccines from coverage.
- Compounded prescriptions
- Contraceptive supplies and devices

The Medicaid prescription drug program does **not** cover the following items or services:

- Drugs supplied by drug manufacturers who have not entered into a federal drug rebate agreement.
- Drugs supplied by other public agencies such as the United States Veteran's Administration, United States Department of Health and Human Services, Indian Health Services, local health departments, etc.
- Drugs prescribed:
  - To promote fertility
  - For weight reduction
  - For cosmetic purposes or hair growth
  - For an indication which is not medically accepted as determined by the Department in consultation with federal guidelines, DUE CARE, or the Department medical and pharmacy consultants.
- Drugs designated as "less-than-effective" ("DESI" drugs), or which are identical, similar, or related to such drugs.
- Prescription vitamins and mineral products in the absence of a condition that is clinically documented to produce a deficiency state, except prenatal vitamins and fluoride preparations. Prenatal vitamins are covered **only** when prescribed and dispensed to pregnant women.
- Drugs that are experimental, investigational, or of unproven efficacy or safety
- Free pharmaceutical samples
- Obsolete National Drug Code (NDC)
- Terminated drug products
- Any drug, biological product, or insulin provided as part of, or incident to and in the same setting as, any of the following:
  - Inpatient hospital setting

- Hospice services
- Outpatient hospital services emergency room visit
- Other laboratory and x-ray services
- Renal dialysis

- Any of the following drugs:
  - Outpatient nonprescription drugs
  - Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
  - Medical supplies (non-drug items) are not covered under the prescription drug program.
- Exception:
  - Contraceptive supplies and devices
  - Specific inhaler supplies

Non-covered services (ARM 37.85.207 and 37.86.3002)

The following is a list of services not covered by Montana Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program (see the *Eligibility* chapter in the *General Information For Providers* manual).

- Acupuncture
- Chiropractic services
- Dietician/nutritional services
- Massage services
- Dietary supplements
- Homemaker services
- Infertility treatment
- Delivery services not provided in a licensed health care facility unless as an emergency service
- Outpatient physical therapy, occupational therapy, and speech therapy services that are primarily maintenance therapy. Providers should refer to the *Therapy Services* manual available on the Provider Information Web Portal (see *Key Contacts*).
- Outpatient hospital services provided outside the United States
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental or investigational
- Claims from outpatient hospitals for pharmaceuticals and supplies only

- Reference lab services. Providers may bill Medicaid only for those lab services they have performed themselves.
- Exercise programs and programs that are primarily educational, such as:
  - Cardiac rehabilitation exercise programs
  - Pulmonary rehabilitation programs
  - Nutritional programs
  - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Services provided to Medicaid clients who are absent from the state, with the following exceptions:
  - Medical emergency
  - Required medical services are not available in Montana. PASSPORT approval is required and prior authorization may also be required for certain services (see the *PASSPORT and Prior Authorization* chapter in this manual).
  - If the Department has determined that the general practice for clients in a particular area of Montana is to use providers in another state
  - When out-of-state medical services and all related expenses are less costly than in-state services
  - When Montana makes adoption assistance or foster care maintenance payments for a client who is a child residing in another state
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid client is financially responsible for these services and the Department recommends the client agree in writing before the services are provided. See *When to Bill a Medicaid Client* in the *Billing Procedures* chapter of this manual.
- Donor search expenses
- Autopsies
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

Importance of Fee Schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information Web Portal (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

PASSPORT and Prior Authorization

What Are PASSPORT, Team Care and Prior Authorization? (ARM 37.86.5101 - 5120)

PASSPORT To Health, the Team Care Program and prior authorization (PA) are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different and are obtained through different processes, and some services may require both (see the *Submitting a Claim* chapter in this manual).

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team Care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *General Information For Providers* manual or the *Team Care* page on the Provider Information Web Portal (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number that must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.

Different codes are issued for PASSPORT approval and prior authorization, and both must be recorded on the UB-92 claim form.

Medicaid does not pay for services when prior authorization or PASSPORT requirements are not met.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Some services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. For example, if a PASSPORT client comes to a plastic surgeon requesting a cosmetic procedure, then PASSPORT approval is required from the PASSPORT provider and prior authorization is required from the Department's SURS unit. Refer to *Prior Authorization* later in this chapter and the fee schedules for PA requirements.

Remember that, if the IHS is not the client's PASSPORT provider and you refer him or her to another Medicaid provider, Medicaid will not pay the claim without the PASSPORT provider's approval.

Indian Health Services and the Managed Care Client

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose an IHS or another provider as their PASSPORT provider. The IHS never needs a PASSPORT referral to provide services to a PASSPORT client. However, if the IHS refers a PASSPORT client to a non-IHS provider, a PASSPORT referral is needed or the services will not be covered by Medicaid.

Role of the IHS PASSPORT Provider

PASSPORT providers manage a client's health care in several ways:

- Provide primary care, including preventive care, health maintenance, and treatment of illness and injury.
- Coordinate the client's access to medically necessary specialty care and other health services. Coordination includes referral, authorization, and follow-up.
- Authorize inpatient admissions.
- Provide or arrange for qualified medical personnel to be accessible 24 hours a day, seven days a week to provide direction to clients in need of emergency care.
- Provide or arrange for suitable coverage for needed services, consultations, and approval of referrals during the provider's normal hours of operation.
- Provide or arrange for Well Child Check Ups and immunizations according to the periodicity schedule in the *Well Child EPSDT* chapter and *Appendix B* of this manual.
- Maintain a unified medical record for each PASSPORT client. This must include a record of all approvals for other providers. Providers must transfer a copy of the client's medical record to a new primary care provider if requested in writing by the client.
- Review PASSPORT utilization rates (supplied by Medicaid) and analyze factors contributing to unusually high or low rates.

Providing PASSPORT referral

- Before referring a PASSPORT client to another provider, verify that the provider accepts Medicaid.
- When referring a client to another provider, you must give that provider your PASSPORT number.
- All referrals must be documented in the client's medical record or a telephone log. Documentation should not be submitted with the claim.
- PASSPORT approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the PASSPORT provider.

Client disenrollment

A provider can ask to disenroll a PASSPORT client for any reason including:

- The provider-client relationship is mutually unacceptable.
- The client fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The client is abusive.
- The client could be better treated by a different type of provider, and a referral process is not feasible.

Providers cannot terminate a provider-client relationship in mid-treatment. To disenroll a client, write to PASSPORT To Health (see *Key Contacts*). Providers must continue to provide PASSPORT management services to the client while the disenrollment process is being completed.

Termination of PASSPORT agreement

To terminate your PASSPORT agreement, notify PASSPORT To Health in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30 day time period to elapse.

Utilization review

PASSPORT providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

Caseload limits

PASSPORT providers may serve as few as one or as many as 1,000 Medicaid clients. Group practices and clinics may serve up to 1,000 clients for each full-time equivalent provider.

Verifying a Client's PASSPORT Eligibility

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. You will be given the PASSPORT provider's name and phone number and whether the client has full or basic Medicaid coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in the *Covered Services* chapter of this manual. Prior authorization requirements must also be followed.

PASSPORT and Emergency Services

PASSPORT provider approval is not required for emergency services. However, if an inpatient hospitalization is recommended as post-stabilization treatment, the hospital must contact the client's PASSPORT provider. If the provider does not respond within 60 minutes, PASSPORT authorization is assumed. You must send documentation to the PASSPORT program officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60-minute time lapse between these two events.

The IHS and PASSPORT Referrals

To find out which services require PASSPORT referral, please see the *PASSPORT Referral* chapter of the *PASSPORT To Health Provider Handbook*.

Getting Questions Answered

For more information about the PASSPORT program, such as enrolling as a PASSPORT provider, case management fees and cost-sharing, please refer to the *PASSPORT To Health Provider Handbook.* The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client Help Lines are available to answer almost any PASSPORT or general Medicaid question. You may call Provider Relations (see *Key Contacts*) to obtain materials for display in your office, discuss any problems or questions regarding your PASSPORT clients, or enroll in PASSPORT. You can keep up with changes and updates to the PASSPORT program by reading the PASSPORT provider newsletters. Newsletters and other information are available on the Provider Information Web Portal (see *Key Contacts*). For claims questions, call Provider Relations.

Complaints and Grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint. If you have a grievance about a PASSPORT issue, you can send it to the PASSPORT Program Officer (see *Key Contacts*).

Prior Authorization

Some services require prior authorization (PA) before they are provided. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included in form locator 63 on the UB-92 claim form.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All transplant services**
• **Out-of-state hospital inpatient services**
• **All rehab services**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In/out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In/out-of-state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.

• **Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)**
 	
(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization.)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** For clients with last names beginning with **A - L**, call: (406) 444-6977 In/out-of-state For clients with last names beginning with **M - Z**, call: (406) 444-0190 In/out-of-state **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Circumcision**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before 5 years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene
		  • Urinary obstruction
		  • Urinary tract infections

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 In/out-of-state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses

• **Prescription drugs** (For a list of drugs that require PA, refer to the *PA Criteria for Prescription Drugs later in this chapter*.)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 443-6002 Helena (800) 395-7961 In/out-of-state **Fax:** (406) 443-7014 Helena (800) 294-1350 In/out-of-state	• Refer to the *PA Criteria for Prescription Drugs* table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is in *Appendix A: Forms*. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the *PA Criteria for Specific Services* table.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Maxillofacial/ cranial surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Surgical services are covered only when done to restore physical function or to correct physical problems resulting from:
		  • Motor vehicle accidents
		  • Accidental falls
		  • Sports injuries
		  • Congenital birth defects
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

• **Blepharoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Reconstructive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking)
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Botox myobloc**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• For more details on botox criteria, coverage, and limitations, visit the Provider Information Web Portal (see *Key Contacts*)
		• Botox is covered for treating the following:
		Laryngeal spasm
		Blepharospasm
		Hemifacial spasm of the nerve
		Torticollis, unspecified
		Torsion dystonia
		Fragments of dystonia
		Hereditary spastic paraplegia
		Multiple sclerosis
		Spastic hemiplegia
		Infantile cerebral palsy
		Other specified infantile cerebral palsy
		Achalasia and cardiospasm
		Spasm of muscle
		Hyperhidrosis
		Strabismus and other disorders of binocular eye movements
		Other demyelinating diseases of the central nervous system
		• Documentation requirements include a letter from the attending physician supporting medical necessity including:
		  • Client's condition (diagnosis)
		  • A statement that traditional methods of treatments have been tried and proven unsuccessful
		  • Proposed treatment (dosage and frequency of injections)
		  • Support the clinical evidence of the injections
		  • Specify the sites injected
		• Myobloc is reviewed on a case-by-case basis

• **Excising excessive skin and subcutaneous tissue**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Required documentation includes the following:
		  • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty septorhinoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g,. a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular joint (TMJ) arthroscopy/ surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an intra-oral orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ is considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Dermabrasion/ abrasion chemical peel**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• Services covered for the following:
		  • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.
		  • The removal of pre-cancerous skin growths (keratoses)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		  • Pre-operative photographs

• **Positron emission tomography (PET) scans**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		• PET scans are covered for the following clinical conditions (for more details on each condition and required documentation, contact the SURS unit):
		  • Solitary pulmonary nodules (SPNs) - Characterization
		  • Lung cancer (non small cell) - Diagnosis, staging, restaging
		  • Esophageal cancer - Diagnosis, staging, restaging
		  • Colorectal cancer - Diagnosis, staging, restaging
		  • Lymphoma - Diagnosis, staging, restaging
		  • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes.
		  • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated.
		  • Head and neck cancers (excluding CNS and thyroid) - Diagnosis, staging, restaging
		  • Myocardial viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan.
		  • Refractory seizures - Covered for pre-surgical evaluation only
		  • Perfusion of the heart using Rubidium 82 tracer (not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction mammoplasty**	Surveillance/ Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - L**, call:
	(406) 444-6977 In/ out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/ out-of-state
	
	Fax:
	(406) 444-0778
		• Both the referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		Indications for female client:
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six-month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		• Documentation in the client's record must indicate and support the following:
		  • History of the client's symptoms related to large, pendulous breasts.
		  • The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		  • Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		  Height — **Weight of tissue per breast**
		  less than 5 feet — 250 grams
		  5 feet to 5 feet, 2 inches — 350 grams
		  5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		  greater than 5 feet, 4 inches — 500 grams
		  • Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		  • Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		Indications for male client:
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

PA Criteria for Prescription Drugs

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case-by-case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long-acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last five years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.
Disease-Modifying Anti-Rheumatic Drugs (DMARD) Arava (leflunomide) Enbrel (etanercept) Humira (adalimumab) Kineret (anakinra) Remicade (infliximab)	• Diagnosis of rheumatoid arthritis • Rheumatology consult with date and copy of consult included • Kineret may be used alone or in combination with DMARDs other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel) • Enbrel whether alone or in combination with methotrexate. • Enbrel or Remicade may be approved with Arava on an individual basis. • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by: • > 10 swollen joints • ≥ 12 tender joints • Elevated serum rheumatoid factor levels or erosions on baseline x-rays • Remicade therapy will be approved only following a negative TB test • Enbrel also covered for psoriasis when accompanied by a prescription from a dermatologist.
Remicade (infliximab)	Also covered for the following diagnoses: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	• Diagnosis of erectile dysfunction • Males only, 18 years of age or older • No concomitant organic nitrate therapy

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Gastro-intestinal Drugs Includes H2 antagonists, proton pump inhibitors, and Cytotec Prior authorization is required only for concomitant usage of an H2 antagonist and a proton pump inhibitor. This PA requirement is designed to avoid therapeutic duplications.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis.
Growth Hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/ milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. **Turner's syndrome:** Chromosomal abnormality showing Turner's syndrome. **Growth hormone deficiency in adults:** • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had a growth hormone deficiency during childhood and now have somatotropin deficiency syndrome (SDS).

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Hypnotic Drugs Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least ***two*** multi-source prescription sleep-inducing drugs.
Migraine Headache Drugs For monthly quantities greater than 9 tablets: Imitrex (sumatriptan): 4 injections (2 kits) **or** 6 units of nasal spray Maxalt (rizatriptan) Zomig (zolmitriptan) and Zomig ZMT (zolmitriptan) Zomig nasal spray 6 units Migranal (dihydroergotamine): 4 units Axert (almotriptan) Frova (frovatriptan) Relpax (electriptan) Amerge (naratriptan HCl)	Indicated only for treatment of ***acute***, migraine/cluster headache attacks for patients who meet the following criteria: • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24 hours • No use of MAOI within previous two weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated Usage of duplicating generic entities are not allowed, but authorization may be approved on an individual basis for concomitant use of differing dosing formulations of the same drug. Concurrent therapy with Stadol will not be covered.
Nonsedating Antihistamine Products	• Prescribed OTC Loratadine products whose manufacturer has a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) will be available to clients without prior authorization (PA) restrictions. • PA required for federal legend brand and generic non-sedating antihistamines. PA may be authorized upon failure of a 14-day trial of OTC Loratadine products
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least ***two*** multiple-source products must be documented.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Oxycodone HCl Controlled-Release (OxyContin)	Prior authorization is required for all dosing above twice a day and above 320 mg per day.
Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	• Diagnosis of ***intermittent claudication*** as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; **and** • The patient has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol are being used as part of a standardized treatment protocol, e.g., bone marrow or oncology treatment protocols.
Proton Pump Inhibitors (PPIs) Prevacid NapraPac	Federal legend, brand and generic proton pump inhibitors (PPIs) may be authorized upon failure of Prilosec OTC 20mg at doses that exceed 40mg per day. Special consideration may be given on an individual basis for patients requiring specific dosing regimens based on the various PPI formulations. Requires that the patient must have tried and failed concomitant use of Prilosec OTC and Naproxen.
Smoking Cessation Drugs Nicotine-replacement products. Patches are the preferred course of therapy. The gum, lozenge and inhaler replacement therapies are only authorized for patients having allergies or intolerance to the patch adhesive. Zyban (buproprion)	Authorization given for four-month course of therapy. Four trials of therapy are allowed.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Stadol (butorphanol) PA required for quantities greater than three 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for patients who meet the following criteria: • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous seven days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.
Thalomid (thalomide)	• Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). • Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a five-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnosis of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tablets)	• Xanax XR tablets may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once-daily dosing only.
Zoloft 25 mg and 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

MHSP PA Criteria for Prescription Drugs

Drug	Criteria
buspirone (Buspar)	• Augmentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least ***two*** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg and 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long-acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, Workers' Compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not.

For details on how Medicaid calculates payment for Medicare claims, see the *How Payment Is Calculated* chapter in this manual.

Medicare Part A claims

Medicare Part A covers inpatient hospital care, skilled nursing care and other services. To date, arrangements have not been made with Medicare Part A carriers for electronic exchange of claims covering Part A services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid on paper.

Medicare Part A crossover claims do not automatically cross over from Medicare.

Medicare Part B crossover claims

Medicare Part B covers outpatient hospital care, physician care and other services. Although outpatient hospital care is covered under Part B, it is processed by Medicare Part A. This means that outpatient hospital claims are completed on a UB-92 form and must be submitted directly to Medicaid. These claims do not automatically cross over from Medicare.

When Medicare pays or denies a service

When outpatient hospital claims for clients with Medicare and Medicaid:

- Are paid, submit the claim to Medicaid on a UB-92 form with the Medicare coinsurance and deductible information in the "Value Codes" form locators (39-41) and Medicare paid amounts in the "Prior Payments" form locator (54). See the *Billing Procedures* and *Submitting a Claim* chapters in this manual.
- Are allowed, and the allowed amount went toward client's deductible, include the deductible information in the "Value Codes" form locators (39-41) and submit the claim to Medicaid on paper.
- Are denied, the provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.

When billing Medicaid for a client with coverage from multiple sources, see the *Billing Procedures* chapter in this manual.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and notification to the Department Third Party Liability Unit:

  Third Party Liability Unit
  Department of Public Health and Human Services
  P.O. Box 202953
  Helena, MT 59620-2953

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
    2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "prior payments" form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information Web Portal (see *Key Contacts*). Until HIPAA implementation, continue to bill on paper with attachments.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the paper claim a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a UB-92 claim form. UB-92 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the 12-month time limit has passed, providers must submit clean claims to Medicaid within:
  - ***Medicare crossover claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
  - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).

- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When to Bill Medicaid Clients (ARM 37.85.406)

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

When to Bill a Medicaid Client (ARM 37.85.406)

	• **Client is Medicaid enrolled** • **Provider accepts client as a Medicaid client**	• **Client is Medicaid enrolled** • **Provider does not accept client as a Medicaid client**	• **Client is not Medicaid enrolled**
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he or she must pay for the services received.

Custom Agreement: This agreement lists the service and date the client is receiving the service and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Medicaid clients who also qualify for IHS and are being treated at an IHS facility are exempt from cost sharing fees.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the IHS provider may:

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

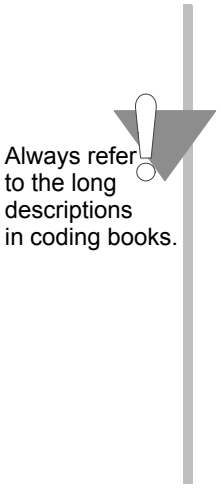
When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local Office of Public Assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*).

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the following table of *Coding Resource*s. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.



- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Bill for the appropriate level of service provided. Evaluation and management services have three to five levels. See your CPT manual for instructions on determining appropriate levels of service.
- Revenue codes 25X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS Level II codes on each line.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm
UB-92 National Uniform Billing Data Element Specifications	Montana UB-92 billing instructions	MHA - An Association of Montana Health Care Providers (formerly Montana Hospital Association) Box 5119 Helena, MT 59604 (406) 442-1911 phone (406) 443-3984 fax

Number of Lines on Claim

Providers are requested to put no more than 40 lines on a UB-92 claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for outpatient claims with 40 lines or fewer.

Multiple Services on Same Date

IHS providers must submit a single claim for all services provided to the same client on the same day. For example, a Medicaid client is seen in an IHS facility in the morning as an outpatient, is admitted in the afternoon to a non-IHS facility, and then seen in the evening by the IHS physician at the non-IHS facility. The IHS facility may bill Medicaid for the clinic visit in the morning, and the non-IHS facility may bill Medicaid for the inpatient services. However, the services provided by the IHS physician in the non-IHS facility may not be billed to Medicaid if the hospital admit is related to the clinic visit in the morning because those services are covered in the morning clinic visit. If the hospital admit is unrelated to the clinic visit, the IHS may bill Medicaid for the IHS physician visit to the non-IHS facility in addition to the clinic visit.

Span Bills

Providers may include services for more than one day on a single claim, so long as the service is billed with the IHS revenue code and the date is shown on the line. See the table *Reimbursement Methods for Specific Services* in the *How Payment Is Calculated* chapter of this manual.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:
    - 51X Clinic
    - 77X Preventive Care Services

IHS Revenue Codes

IHS providers may bill Medicaid with the revenue codes shown in the following table using their IHS provider number. If an IHS is providing a service not shown here, the IHS must enroll with Medicaid as a provider of the service and bill Medicaid using the Medicaid provider number assigned to that provider type. See *Billing Procedures for Specific Services* later in this chapter.

IHS Revenue Codes for Billing Medicaid

Service	Revenue Code	Description
Inpatient	100	All inclusive room, board plus ancillary
Outpatient Clinic Visit	500	General class outpatient clinic services (physician, mid-level, therapy, etc.)
Prescription Refills	250	General class pharmacy
Vision	519	Outpatient clinic visit for vision services
Dental	512	Dental clinic visit
Psychiatric	513	Psychiatric clinic visit
Inpatient Physician Visit	987	Professional fees - hospital visit
VFC Administration	771	Vaccine administration
Synagis	259	Premature infant injection

Billing for Specific Services

Prior authorization is required for some services. PASSPORT and prior authorization are different, and some services may require both (see the *PASSPORT and Prior Authorization* chapter in this manual). Different codes are issued for each type of approval and must be included on the claim form (see the *Submitting a Claim* chapter in this manual).

Some services provided by an IHS are billed with the IHS provider number and codes specific to IHS (see previous table *IHS Revenue Codes for Billing Medicaid*). Other services require the IHS to enroll as a Medicaid provider for the type of services provided (i.e., dialysis clinic services, nursing facility services, home health, etc.) and are billed using the Medicaid provider number assigned to that provider type. All providers must be enrolled with Medicaid before billing for services. The following table describes billing procedures for different services.

Every claim for Medicaid services must indicate the provider of service. Claims for services rendered in IHS facilities are submitted using the IHS facility's provider number. However, when services are rendered in a non-IHS facility, the claim should be submitted using the individual's provider number.

IHS physicians do not receive reimbursement directly from Medicaid but from the IHS. IHS providers must show the Billings Area Indian Health Services as the "pay to" address on the enrollment form so that all payments will go directly to the IHS office.

Billing Procedures for Specific Services

All manuals referenced here are available on the mtmedicaid.org website.

Service	Billing Method	Medicaid ID Number for Billing
Ambulance	Bill Medicaid according to the instructions in the *Ambulance Services* manual.	Ambulance provider number
Audiology	Bill Medicaid using the IHS clinic visit revenue code.	IHS provider number
Chiropractor (QMB and children under 20 only)	Bill Medicaid according to the instructions in the *Chiropractic Services* manual.	Chiropractic provider number
Dental	Bill Medicaid using the IHS dental revenue code.	IHS provider number
Denturist	Bill Medicaid according to the instructions in the *Dental and Denturist Services* manual.	Denturist provider number
Dialysis Clinic	Bill Medicaid according to the instructions in the *Dialysis Clinic Services* manual.	Dialysis clinic provider number
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)	Bill Medicaid according to the instructions in the *Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies* manual.	DME provider number
EPSDT (children age 21 and under)	Bill Medicaid using the IHS clinic visit revenue code.	IHS provider number
Eyeglasses	Eyeglass purchases must be made through the Department's eyeglass contractor. See the *Optometric and Eyeglass Services* manual. The eyeglass contractor bills Medicaid for lab and materials and the optometric provider bills Medicaid for the clinic visit.	Billed by the Department's eyeglass contractor.
Family Planning	Bill Medicaid using the IHS clinic visit revenue code.	IHS provider number
Free-standing Dialysis Clinic	Bill Medicaid according to the instructions in the *Dialysis Clinic Services* manual.	Dialysis clinic provider number
Hearing Aids	Bill Medicaid according to the instructions in the *Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies* manual.	Hearing aid provider number
Home and Community Services (HCBS)	Bill Medicaid according to the instructions in the *Home and Community Based Services* manual.	HCBS provider number
Home Dialysis	Bill Medicaid according to the instructions in the *Dialysis Clinic Services* manual.	Home dialysis provider number
Home Health	Bill Medicaid according to the instructions in the *Home Health Services* manual.	Home health provider number
Home Infusion Therapy	Bill Medicaid according to the instructions in the *Home Infusion Therapy Services* manual.	Home infusion therapy provider number
Inpatient/Outpatient Hospital	Bill Medicaid using the IHS inpatient or outpatient hospital visit revenue code.	IHS provider number

Billing Procedures for Specific Services (continued)

All manuals referenced here are available on the mtmedicaid.org website.

Service	Billing Method	Medicaid ID Number for Billing
Lab and X-ray	These services are included in the IHS clinic visit revenue code; do not bill separately for lab and x-ray services.	N/A
Licensed Professional Counselor	Bill Medicaid using the IHS psychiatric revenue code.	IHS provider number
Nursing Facility	Bill Medicaid according to the instructions in the *Nursing Facility and Swing Bed Services* manual.	Nursing facility or swing bed provider number
Occupational Therapy	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider number
Optician/Optometry	Bill Medicaid using the IHS vision clinic visit revenue code.	IHS provider number
Outpatient Clinic	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider number
Oxygen	Bill Medicaid according to the instructions in the *Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies* manual or the *Nursing Facility and Swing Bed Services* manual.	DME provider number
Personal Assistance	Bill Medicaid according to the instructions in the *Personal Assistance Services* manual.	Personal assistance provider number
Pharmacy	Bill Medicaid using the IHS pharmacy prescription refill code.	IHS provider number
Physical Therapy	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider number
Physician and Mid-Level Practitioner IHS Clinic Visit	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider number
Physician and Mid-Level Practitioner IHS Inpatient Hospital Visit/Service	Bill Medicaid using the IHS inpatient physician visit revenue code.	IHS provider number
Physician and Mid-Level Practitioner Non-IHS Inpatient Visit	• For an inpatient visit from an IHS physician (at a non-IHS facility), bill Medicaid using the IHS inpatient physician visit revenue code. • For an inpatient visit from a non-IHS physician (at a non-IHS facility), the physician bills Medicaid using the *Physician and Mid-Level Practitioner* manual.	• IHS provider number for IHS physician • Physician provider number for non-IHS physician
Podiatry	Bill Medicaid according to the instructions in the *Physician-Related Services* manual.	Physician provider number
Prosthetics	Bill Medicaid according to the instructions in the *Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies* manual.	DME provider number
Psychologist	Bill Medicaid using the IHS psychiatric revenue code.	IHS provider number

Billing Procedures for Specific Services (continued)
All manuals referenced here are available on the mtmedicaid.org website.

Service	Billing Method	Medicaid ID Number for Billing
Residential Treatment Center	Bill Medicaid according to the instructions in the *Mental Health Services* manual.	Mental health provider number
RHC and FQHC	Bill Medicaid according to the instructions in the *FQHC and RHC Services* manual.	RHC or FQHC provider number
School-Based Services	Bill Medicaid according to the instructions in the *School-Based Services* manual.	School-based services provider number
Social Worker	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider number
Speech Therapy	Bill Medicaid using the IHS outpatient clinic visit revenue code.	IHS provider number
Swing Bed	Bill Medicaid according to the instructions in the *Nursing Facility and Swing Bed Services* manual.	Nursing facility or swing bed provider number
Targeted Case Management (TCM)	Bill Medicaid according to the instructions in the *Targeted Case Management Services* manual.	TCM provider number
Transportation	Bill Medicaid according to the instructions in the *Commercial and Specialized Non-Emergency Transportation Services* manual.	Transportation provider number

Submitting a Claim

See the *Submitting a Claim* chapter in this manual for instructions on completing claim forms, submitting paper and electronic claims, and inquiring about a claim.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **seven-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. PASSPORT approval is different from prior authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Prior authorization is different from PASSPORT authorization (see the *PASSPORT and Prior Authorization* chapter in this manual).
Prior authorization does not match current information	Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual).
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

Institutional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the EDI Help Desk (see *Key Contacts*).
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact the EDI Help Desk (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in any format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing electronically with paper attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a *Paperwork Atachment Cover Sheet* (located on the Provider Information Web Portal and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed electronically or on UB-92 claim forms. Please use this chapter with the *Montana UB-92 Reference Manual*. For more information on submitting HIPAA compliant 837 transactions, refer to the *Companion Guides* on the ACS EDI Gateway website (see *Key Contacts*). Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

When completing a claim, remember the following:

- Please use this information together with the UB-92 Reference Manual.
- Most form locators shown in this chapter are required or situational. Situational form locators are required if the information is applicable to the situation or client and are indicated by "*".
- Form locator 11 is used for PASSPORT and FL 78 is used for cost sharing indicators (see following table and instructions in this chapter).

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete and submit the form to Provider Relations (see *Key Contacts*).

Provider Relations will respond to the inquiry within seven to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

PASSPORT and Cost Sharing Indicators

PASSPORT To Health Indicators	
Code	**Description**
FPS	This indicator is used when providing family planning services.
OBS	This indicator is used when providing obstetrical services.
TCM	This indicator is used when providing targeted case management services.
Cost Sharing Indicators	
E	This indicator is used when providing emergency services.
F	This indicator is used when providing family planning services.
P	This indicator is used when providing services to pregnant women.

- Unless otherwise stated, all paper claims must be mailed to the following address:

  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Client Has Medicaid Coverage Only

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4	Type of bill	Enter the code indicating the type of bill (see the UB-92 Reference Manual for specific codes)
6	Statement covers period	The beginning and ending service dates of the period included on this bill
11*	PASSPORT To Health	Enter PASSPORT authorization number or indicator (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and ZIP code
14	Patient birth date	The client's month, day, and year of birth
15	Patient sex	Use M (male), F (female), or U (unknown)
17-20	Admission	The admission date, hour, type, and source (see the UB-92 Reference Manual for specific codes)
22	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate)
44	HCPCS rates	Enter the HCPCS code for each service
45	Service date	The date the indicated service was provided
46	Service units	A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	Enter "Medicaid" when the client has Medicaid only coverage
51	Provider number	Enter the provider's Medicaid ID number
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60	Cert - SSN - HIC - ID #	Client's Medicaid ID number
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers and some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75
76	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing indicator (see *PASSPORT and Cost Sharing Indicators* at the beginning of this chapter)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number.
85-86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill

Client Has Medicaid Coverage Only

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Open Range PHS Indian Health Ctr. 33 Best Road Open Range, MT 59003		343397	731

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	09/05/05	09/15/05					9989887

12 PATIENT NAME	13 PATIENT ADDRESS
Sunshine, Bright R.	493 Lighthouse Way Open Range, MT 59003

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
8/28/49	F		09/05/05	00				01									

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	General Class Pharmacy		09/05/05	1	150.00		
2	500	Outpatient Services General Class	99212	09/12/05	1	216.00		
3	250	General Class Pharmacy		09/15/05	1	150.00		
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23						516.00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	0413214					
B							
C							

57 **DUE FROM PATIENT ▶**

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Sunshine, Bright R.		123784560		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
244.9	716.59	272.4	311	V68.1					244.9		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID: 0003421 Dr. Smiling

83 OTHER PHYS. ID: A

OTHER PHYS. ID: B

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Betty Billing Agent

86 DATE: 09/23/05

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 Agreement

Your signature on the UB-92 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required form locator is blank	Check the claim instructions earlier in this chapter for required form locators. If a required form locator is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required form locator (FL 60); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility verification (see the *General Information For Providers*, *Client Eligibility* chapter).
Client name missing	This is a required form locator (FL 12); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a seven-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim (FL 51).
PASSPORT provider name and ID number missing	When services are not provided by the client's PASSPORT provider, include the provider's PASSPORT number (FL 11) (see the *PASSPORT and Prior Authorization* chapter in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in FL 63 (see *PASSPORT and Prior Authorization* in this manual).
Not enough information regarding other coverage	Form locators 39-41, 50, and in some cases 54, are required when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers may select a one- or two-week payment cycle (see *Payment and the RA* later in this chapter). Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

Due to HIPAA regulations, the APC and the lab panel it bundled to will not show on the RA.

RA notice

The RA notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that affect providers and claims.

Paid claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).

If a claim was denied, read the description of the reason and remark code before taking any action on the claim.

Denied claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark Codes column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. Please make necessary changes to the claim before rebilling Medicaid.

Pending claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

The pending claims section of the RA is informational only. Do not take any action on the claims shown here.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604
REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP (1)

OPEN RANGE PHS INDIAN HEALTH CENTER
33 BEST ROAD
OPEN RANGE, MT 59003

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/02 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	010303 010303	1	350	810.00	163.04	N	
ICN (9)	00204011350000700			350	95.00	92.56		
		LESS MEDICARE PAID*******				724.00		
		LESS COPAY DEDUCTION**				5.00 (17)		
		CLAIM TOTAL*******			905.00			
DENIED CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	020103 020103	1 (16)	300	9.00	0.00	Y	
ICN	00204011350000800	020303 020303	1	300	22.00	0.00 (17)	Y	
		CLAIM TOTAL*******			31.00	8.24		31 MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS								
123456789	DOE, JOHN EDWARD	020403 020403	1	350	810.00	0.00 (17)	N	31
ICN	00204011350000900							
		CLAIM TOTAL*******			810.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

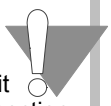
Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The seven-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000, was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns.
11. Unit of service	The units of service rendered under this procedure, NDC code or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark code	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.



The credit balance section is informational only. Do not post from credit balance statements.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations (see *Credit balances* #2 above) to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Submitting a Claim* chapters.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code, make the appropriate corrections, and resubmit the claim on a UB-92 form (not the adjustment form).
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

Rebill denied claims only after appropriate corrections have been made.

How to rebill

- Check any reason and remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Submitting a Claim* chapter*, Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th

Adjustments can only be made to paid claims.

digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).
- Request an adjustment when a single line on a multi-line claim was denied.

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*. You may also order forms from Provider Relations or download them from the Provider Information website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS: Open Range PHS
Name: 33 Best Road
Street or P.O. Box: Open Range, MT 59003
City State Zip
2. CLIENT NAME: Jane Doe
3. INTERNAL CONTROL NUMBER (ICN): 00204011250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT ID NUMBER: 123456789
6. DATE OF PAYMENT: 02/15/05
7. AMOUNT OF PAYMENT $: 150.00

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/05	01/23/05
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 04/15/05

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and the RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic funds transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. To arrange for EFT, call the number listed under *Direct Deposit Arrangements* in *Key Contacts*.

Electronic remittance advice

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have internet access, and be registered for the Montana Access to Health Web Portal. You can access your electronic RA through the Web Portal on the internet by going to the Provider Information Web Portal (see *Key Contacts*) and selecting Log In to Montana Access to Health. In order to access the Montana Access to Health Web Portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

Electronic RAs are available for only 90 days on the web portal.

After these forms have been processed, you will receive a user ID and password that you can use to log on to the Web Portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement,* but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Web Portal home page. Due to space limitations, each RA is only available for 90 days.

Required Forms for EFT and/or Electronic RA

All four forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health Web Portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement)	• Provider Information Web Portal • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information Web Portal (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form)	• Provider Information Web Portal • ACS EDI Gateway website (see *Key Contacts)*	ACS address on the form

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Montana Medicaid payments to IHS Medicaid facilities are contracted. Medicaid pays outpatient IHS services on an all-inclusive encounter basis and pays for inpatient services using a per diem payment.

Montana operates the Indian Health Services according to the State Plan. It states, "Services provided by Indian Health Services and/or tribal 638 facilities are paid with federal funds according to rates prescribed by the Centers for Medicare and Medicaid Services (CMS) and established by the U.S. Public Health Services for Indian Health Services as set forth in the Federal Register. Subsequent payment adjustments will be made pursuant to changes published in the Federal Register.

Section 1905(b) of the Social Security Act (the Act) provides that 100 percent Federal Medical Assistance Percentages (FMAP) is available to states for amounts spent on medical assistance received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

Physician services provided by IHS physicians in non-IHS facilities are NOT eligible for 100 percent federal funds, but rather at the regular federal/state match rate of approximately 70 percent federal funds and 30 percent state funds. Montana Medicaid pays for these physician services by utilizing the Medicare Resource-Based Relative Value Scale (RBRVS) with a Montana specific conversion factor.

IHS Rates Established by CFR

IHS/tribal facilities are paid in accordance with the most current Federal Register Notice, published by IHS and approved by CMS.

Services provided by facilities of the Indian Health Service, which include at the option of a tribe or tribal organization, services by tribal 638 facilities funded by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638), are paid at the rates negotiated between CMS and the IHS and published in the Federal Register.

Payment for IHS/tribal 638 inpatient hospital services is made in accordance with the most current inpatient hospital per diem rate published in the Federal Register by the Indian Health Service.

Payment for IHS/tribal 638 outpatient services is made in accordance with the most current outpatient per-visit rate published by the Indian Health Service in the Federal Register.

IHS Negotiated Rates

Payment for inpatient physician services is based on 69 percent of the outpatient rate. This is a negotiated rate with the State and the Billings Area Indian Health Service.

Other Payment Rates

Payment for vaccinations are paid at $9.50.

Payment for Synagis is paid at $582 per 50 mg vial.

All IHS services performed in an IHS facility, whether paid as fee for service or at CFR rates, are 100 percent Federal Pass Through (see following table).

Reimbursement Method for Specific Services
All manuals referenced here are available on the mtmedicaid.org website

Service	Reimbursement Method
Ambulance	Medicaid fee for service. See the Medicaid Ambulance fee schedule and the *How Payment Is Calculated* chapter of the *Ambulance Services* manual.
Audiology	IHS contract rate
Chiropractor (QMB and children under 20 only)	Medicaid fee for service. See the Chiropractic fee schedule and the *How Payment Is Calculated* chapter in the *Chiropractic Services* manual.
Dental	IHS contract rate
Denturist	Medicaid fee for service. See the Medicaid Dental and Denturist fee schedule and the *How Payment Is Calculated* chapter in the *Dental and Denturist Services* manual.
Dialysis Clinic	Medicaid negotiated rate. See the *How Payment Is Calculated* chapter in the *Dialysis Clinic Services* manual.
Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)	Medicaid fee for service. See the Medicaid *DMEPOS* fee schedule and the *How Payment Is Calculated* chapter in the *DMEPOS* manual.
EPSDT (children age 21 and under)	IHS contract rate
Eyeglasses	Contractor's Medicaid rate. See the *How Payment Is Calculated* chapter in the *Optometric and Eyeglass Services* manual.

Reimbursement Method for Specific Services (continued)

All manuals referenced here are available on the mtmedicaid.org website

Service	Reimbursement Method
Family Planning	Per IHS contract
Free-standing Dialysis Clinic	Medicaid per diem rate. See the *How Payment Is Calculated* chapter in the *Dialysis Clinic Services* manual.
Hearing Aids	Medicaid fee for service. See the Medicaid Hearing Aid fee schedule and the *How Payment Is Calculated* chapter in the *Audiology and Hearing Aid Services* manual.
Home and Community Services	Medicaid fee for service. See the Medicaid Home and Community Based Services fee schedule and the *How Payment Is Calculated* chapter in the *Home and Community Based Services* manual.
Home Dialysis	Medicaid fee for service.
Home Health	Fee for service. See the Medicaid Home Health fee schedule and the *How Payment Is Calculated* chapter in the *Home Health Services* manual.
Home Infusion Therapy	Fee for service. See the Medicaid Home Infusion fee schedule and the *How Payment Is Calculated* chapter in the *Home Infusion Therapy Services* manual.
Inpatient/Outpatient Hospital/ Outpatient Clinic	Rate established by the U.S. Public Health Service for IHS; inpatient physician services are paid by negotiated rate between Department and IHS.
Lab and X-ray	IHS contract rate; no separate payment.
Licensed Professional Counselor	IHS contract rate
Nursing Facility	Medicaid per diem rate and fee for service for some ancillary services. See the Medicaid Nursing Facility fee schedule and the *How Payment Is Calculated* chapter in the *Nursing Facility and Swing Bed Services* manual.
Occupational Therapy	IHS contract rate
Optician/Optometry	IHS contract rate
Oxygen	Medicaid fee for services. See the Medicaid fee schedule for the service setting, e.g., physician, DMEPOS, nursing facility, etc. See also the *How Payment Is Calculated* chapter in the corresponding manuals.
Personal Assistance	Fee for service. See the Medicaid personal assistance fee schedule.
Pharmacy	Refills paid per IHS contract; initial prescription included in physician payment.
Physical Therapy	IHS contract rate
Physician and Mid-Level Practitioner IHS Clinic Visit	IHS contract rate
Physician and Mid-Level Practitioner IHS Inpatient Hospital Visit/Service	IHS negotiated rate at 69 percent of outpatient rate.

Reimbursement Method for Specific Services (continued)

All manuals referenced here are available on the mtmedicaid.org website

Service	Reimbursement Method
Physician and Mid-Level Practitioner Non-IHS Inpatient Visit	IHS contract rate
Podiatry	Fee for service. See the Medicaid Podiatry fee schedule and the *How Payment Is Calculated* chapter of the *Physician-Related Services* manual.
Prosthetics	Medicaid fee for services. See the Medicaid *DMEPOS* fee schedule and the *How Payment Is Calculated* chapter in the *DMEPOS* manual.
Psychologist	IHS contract rate
Residential Treatment Center	Per diem rate. See the *How Payment Is Calculated* chapter in the *Mental Health Services* manual.
RHC and FQHC	Per diem rate. See the *How Payment Is Calculated* chapter in the *FQHC and RHC Services* manual.
School-Based Services	Fee for service. See the Medicaid School-Based Services fee schedule and the *How Payment Is Calculated* chapter in the *School Based Services* manual.
Social Worker	IHS contract rate
Speech Therapy	IHS contract rate
Swing Bed	Medicaid per diem rate and fee for service for some ancillary services. See the Medicaid Nursing Facility fee schedule and the *How Payment Is Calculated* chapter in the *Nursing Facility and Swing Bed Services* manual.
Targeted Case Management	Fee for service. See the Medicaid Targeted Case Management fee schedule and the *How Payment Is Calculated* chapter in the *Targeted Case Management Services* manual.
Transportation	Fee for service. See the Medicaid Commercial and Specialized Non-Emergency Transportation fee schedule and the *How Payment Is Calculated* chapter in the *Commercial and Specialized Non-Emergency Transportation Services* manual.

Appendix A: Forms

- ***Montana Medicaid/MHSP/CHIP Individual Adjustment Request***
- ***Paperwork Attachment Cover Sheet***
- ***Montana Medicaid Claim Inquiry Form***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City State Zip

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Billable Visit
A documented one-on-one visit between a Medicaid eligible beneficiary and a qualified health care professional where a Medicaid covered service is provided.

Bundled
Items or services that are deemed integral to performing a procedure or visit that are not paid separately, but are packaged (also called bundled) into the payment for the procedure or visit.

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned Medicare (usually a percentage). Medicare coinsurance is usually 20 percent of the Medicare allowed amount.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

Date of Submission
The date the claim is stamped received by ACS or the Department. A claim lost in the mail is not considered received.

Designated Professional Review Organization
The organization or its agents or representatives with whom the State has contracted to provide professional review of medical claims.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions:
  - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services
Inpatient and outpatient hospital services that are necessary to treat an emergency medical condition (see above).

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Inpatient Hospital Services
Services that are ordinarily furnished in a hospital, under the direction of a physician or dentist, for the care and treatment of inpatients. The services are furnished in an institution that

- Is maintained primarily for the care and treatment of patients with disorders other than mental diseases.
- Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting.
- Meets the requirements for participation in Medicare as a hospital.
- Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of Section 482.3 of Title 42 of the Code of Federal Regulations, unless a waiver has been granted by the Secretary.

Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing bed approval.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Indian Health Service (IHS) Facility
An IHS facility is an entity that is either owned or leased by the Indian Health Service of the Public Health Service. The IHS equates facilities that are leased by IHS to those that are owned by IHS for purposes of defining an IHS facility. IHS keeps a specific listing of its owned and leased facilities. Some IHS facilities, although owned by IHS, may be operated by a tribe or tribal organization.

Indian Health Service Free-Standing Facility
A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians who do not require hospitalization.

Indian Health Services Provider-Based Facility
A facility or location owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services by, or under

the supervision of, physicians to American Indians who are admitted as inpatients or outpatients.

Individual Adjustment
A request for a correction to a specific paid claim.

Inpatient
A patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who receives room, board, and professional services in the institution for a 24-hour period or longer, or is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer. The client is considered an inpatient even though he or she dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Montana Access to Health (MATH) Web Portal
A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical

Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

Outpatient
A patient of an organization medical facility, or distinct part of that facility, who receives professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Outpatient Services
Preventive, diagnostic, therapeutic, rehabilitative or appalliative services that are furnished to outpatients by or under the direction of a physician, dentist, or mid-level practitioner (physician assistant, nurse practitioner, nurse mid-wife, or other specialized nurse practitioner as defined in Section 406.2401 and 491.2 of Title 42 of the Code of Federal Regulations).

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Patient Day
An individual present and receiving medical services in a facility for a whole 24-hour period. Even though an individual may not be present for a whole 24-hour period on the day of admission, such a day will be considered a patient day. The day of discharge will not be counted as a patient day except when the patient is admitted and discharged on the same day.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Reference Lab Billing
Reference lab billing occurs when a Medicaid provider draws a specimen and sends it to a "reference lab" for processing. The reference lab then sends the results back to the Medicaid provider and bills the provider for the lab service. The Medicaid provider is then expected to bill Medicaid for the lab service. Medicaid does not cover lab services when they are billed by the referring provider.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)
SHS or Children's Special Health Services (CSHS) assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Tribal 638 Free Standing Facility
A facility or location owned and operated by a federally recognized American Indian Tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

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